

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS417AGZ	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/07/2008
NAME OF PROVIDER OR SUPPLIER THE MEADOWS HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 4300 DEL MONTE AVENUE LAS VEGAS, NV 89102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted at your facility on 11/07/08.</p> <p>The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006.</p> <p>The facility was licensed as a ten (10) beds, Residential Facility for Groups which provides care to persons with Alzheimer's disease, Category II residents.</p> <p>The census at the time of the survey was eight (8) residents.</p> <p>Six (6) of six (6) employee files were reviewed.</p> <p>Eight (8) of eight (8) resident files were reviewed.</p> <p>There were no complaints investigated during the survey.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>The facility was found to be in substantial compliance with the regulations regarding this survey. No further action is necessary concerning this report. Please retain this copy for your records.</p>	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE